

Health and Human Service System **REGULATION & LICENSURE - CHILD CARE LICENSING** **Health Information Report**



PART A - INDIVIDUAL INFORMATION THIS SECTION TO BE COMPLETED BY INDIVIDUAL.		
Name		Birthdate
Street Address	City	Telephone
Name and Address of Facility for Whom You Work (If other than own home)		
Name of Facility	Street Address	
City	State	Zip Code
INDIVIDUAL HEALTH HISTORY		
MEDICATIONS	List the Medications you are taking: (If none, indicate this)	
Are you being treated for/or have you ever been treated for: Drug Addiction: <input type="checkbox"/> Yes <input type="checkbox"/> No Alcoholism: <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Illness: <input type="checkbox"/> Yes <input type="checkbox"/> No		
In general, my mental and physical health is:		
Signature of Individual SIGN HERE		Date

PART B - HEALTH EXAMINATION This section is to be completed by the Medical Practitioner.	
Blood Pressure	Urinalysis
	Albumin _____ Sugar _____
Is individual under treatment for Hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does individual have any Communicable Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
<p><i>NOTE TO PHYSICIAN: This person will be caring for children. If individual is on medication, has a blood pressure higher than 160/95, or the above tests read positive or "YES," will this affect the individuals ability to care for children?</i></p> <p align="center"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

Comments:

Must be signed by Physician, Physician's Assistant, RN or CNP SIGN HERE	Date
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RETURN TO	Physician (Please print or type)
	Address (City, State and Zip Code)
	Telephone Number